Washington State Department of Health

Immediately notify
DOH Communicable Disease Epidemiology
Phone: 877-539-4344

Poliomyelitis

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Fever** Highest measured temp: _____ °F
				Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	**Headache**
☐	☐	☐	☐	**Stiff neck/back**
☐	☐	☐	☐	**Muscle aches or pain (myalgia)**
☐	☐	☐	☐	Malaise
☐	☐	☐	☐	Nausea
☐	☐	☐	☐	Vomiting

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Immunocompromised

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	**Paralysis or weakness**
				☐ Acute flaccid paralysis ☐ Asymmetric
				☐ Symmetric ☐ Ascending ☐ Descending
☐	☐	☐	☐	Decreased/absent tendon reflexes
☐	☐	☐	☐	Acute onset

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Vaccination

Y	N	DK	NA	
☐	☐	☐	☐	Primary series complete for current disease
☐	☐	☐	☐	Vaccine up to date for current disease

Year of last dose: _____
☐ IPV ☐ OPV
Vaccine series not up to date reason:
☐ Religious exemption
☐ Medical contraindication
☐ Philosophical exemption
☐ Previous infection confirmed by laboratory
☐ Previous infection confirmed by physician
☐ Parental refusal ☐ Under age for vaccination
☐ Other: _____
☐ Unk

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___

P	N	I	O	NT	
☐	☐	☐	☐	☐	**Polio virus culture (stool, CSF or oropharyngeal secretions)**

Vaccine strain: ☐ 1 ☐ 2 ☐ 3
Wild strain: ☐ 1 ☐ 2 ☐ 3

☐ ☐ ☐ ☐ ☐ **Pleocytosis (CSF)**

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

	Exposure period		***Contagious period***	
Days from onset:	-35	-3	1 week prior	onset to 6+ weeks after onset
Calendar dates:				

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
  Out of: ☐ County ☐ State ☐ Country
  Destinations/Dates: _____
  _____
- ☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness
- ☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed or probable case**
- ☐ ☐ ☐ ☐ Contact with recent foreign arrival
  Specify country: _____
- ☐ ☐ ☐ ☐ Contact with recent OPV vaccinee
- ☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

Y N DK NA

- ☐ ☐ ☐ ☐ Congregate living
  ☐ Barracks ☐ Corrections ☐ Long term care
  ☐ Dormitory ☐ Boarding school ☐ Camp
  ☐ Shelter ☐ Other: _____
- ☐ ☐ ☐ ☐ Source of drinking water known
  ☐ Individual well ☐ Shared well
  ☐ Public water system ☐ Bottled water
  ☐ Other: _____
- ☐ ☐ ☐ ☐ Drank untreated/unchlorinated water (e.g. surface, well)
- ☐ ☐ ☐ ☐ Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

- ☐ ☐ ☐ ☐ Attends child care or preschool
- ☐ ☐ ☐ ☐ Employed in child care or preschool
- ☐ ☐ ☐ ☐ Do any household members work at or attend childcare or preschool
- ☐ ☐ ☐ ☐ Documented transmission
  ☐ Child care ☐ School ☐ Doctor's office
  ☐ Hospital ward ☐ Hospital ER
  ☐ Hospital outpatient clinic ☐ Home
  ☐ College ☐ Work ☐ Military
  ☐ Correction facility ☐ Church
  ☐ International travel ☐ Other: _____ ☐ Unk
- ☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Strict isolation for incubation period
- ☐ Public announcement recommended
- ☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___

Poliomyelitis: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered